Survey database. The study population included individuals above 18 years of age, suffering from depression (ICD-9-CM: 296, 300, and 311). HRQOL was assessed using SF-12 physical component summary (PCS) and mental component summary (MCS) scores. The significant predictors of HRQOL were identified using a multiple logistic regression model. SAS version 9.1 (SAS institute, Cary, NC) was used for data analysis. **RESULTS:** 2971 individuals were identified with depression. Impairments in both the domains of HRQOL were found. Young adults (OR=0.198, 95%CI =0.116-0.337) were significantly less likely of showing lower PCS scores as compared to older adults. Unemployed (OR=2.5, 95%CI= 1.981-3.182), less educated (OR=1.49, 95%CI =1.20-1.84) and individuals reporting poor perceived health (OR=1.62, 95%CI =1.43-12.99) had significantly higher odds of showing lower PCS scores compared to employed, more educated individuals having a better perceived health . Furthermore, middle aged adults (OR=2.41, 95%CI =1.78-3.28), unemployed (OR=1.38, 95%CI =1.08-1.76),less educated(OR=1.31, 95%CI =1.07-1.62) and individuals showing poor mental health (OR=3.1,95%CI=2.27-4.24) and overall perceived health (OR=1.72,95%CI=1.32-2.25)showed significantly lower MCS scores. This was observed in comparison to older, employed, more educated individuals reporting good overall health and mental health status. **CONCLUSIONS:** Sociodemographically disadvantaged people and people reporting lower perceived health status are at greater risk of having a poor quality of life. The factors identified in this study should be further investigated to evaluate why such differences exist in quality of life of depressed individuals.

PMH51

PSYCHOMETRIC EVALUATION OF DISEASE SPECIFIC HEALTH RELATED QUALITY OF LIFE INSTRUMENTS IN EATING DISORDERS

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OBJECTIVES: Eating disorders are psychological conditions characterized by disturbed eating habits affecting approximately 30% of teen girls with significant effects on their health related quality of life (HRQL). The objective of this study was to compare and contrast psychometric properties of eating disorder specific HRQL instruments. **METHODS:** HRQL instruments were included in this review if they were available in English, and there was at least one publication citing psychometric properties. Study instruments were evaluated based on: conceptual model, versatility (type of disorder), practicality, depth (<15%), reliability (internal consistency and test-retest), construct validity (convergent and divergent or confirmatory factor analysis), and responsiveness. **RESULTS:** Six instruments were identified: Eating disorder quality of life (EDQOL), eating disorder quality of life scale (EDQLS), health related quality of life in eating disorder and its abbreviated version (HeRQoLED v2), Quality of life for eating disorders (QOL ED), and eating disorder well-being scale (EDwell). All instruments were developed for self-administration, taking 5-15minutes to complete, designed for use in female teens/adults supported by construct validity data, with most scales supporting group- as opposed to individual- level decision making. Only HeRQoLEDv2 was developed for use in both genders. Lack of meeting study criteria may be attributed to missing data, e.g., test-retest reliability. None of the six instruments met all study criteria; however, EDQLS and HeRQoLEDv2 met almost all study criteria. **CONCLUSIONS:** All eating disorder instruments reviewed were developed within the last 10 years with available data being inadequate to assess all scales. Similar to Tirico et al. (2000), in the present study EDQLS and HeRQoLEDv2 met most of the study criteria, in contrast, EDQOL was excluded from this list due to missing data, Study data supported individual level decision making only for the HeRQoLEDv2.

PMH52

THE EFFECT OF VORTIOXETINE ON FAMILY FUNCTIONING IN ADULTS WITH MAJOR DEPRESSIVE DISORDER

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OBJECTIVES: Few studies have measured the impact of antidepressant treatment on family functioning. The effect of vortioxetine and agomelatine on different domains of family functioning was measured using the Depression and Family Functioning Scale (DFFS), comprising 15 items, each rated from 0-4. **METHODS:** The DFFS was assessed in REVIVE, a randomized, double-blind study of adults with an inadequate response to antidepressant treatment for the current depressive episode switched to vortioxetine or agomelatine (NCT01488071). Pre-specified analyses of patients with baseline and follow-up DFFS assessments were performed using change from baseline to weeks 8 and 12, analyzed by mixed models for repeated measurements (MMRM). Descriptive statistics characterizing depressive symptoms (Montgomery-Åsberg Depression Rating Scale; MADRS), functioning (Sheehan Disability Scale; SDS), and quality of life (QoL; EQ-5D) were stratified according to DFFS total score quartiles at baseline. **RESULTS:** The DFFS total score was ~29 at baseline. Vortioxetine (n=189) was superior to agomelatine (n=187) by 2.9 (95% CI [-4.7 to -1.1]) points at week 8 ($p<0.01$) and at week 12 by 2.5 (95% CI [-4.5 to -0.5; $p<0.05$]) points. Improvements in the DFFS total score and items were observed from baseline to week 8 (-10.8±0.7 (vortioxetine) and -7.9±0.7 (agomelatine), with further improvement at week 12 (-13.5±0.8 (vortioxetine) and -11.0±0.8 (agomelatine)). At baseline, the level of family functioning was associated with functional and QoL impairment and, to a lesser extent, depressive symptoms (SDS total=14.66, 19.31, 20.25, 21.68; EQ-5D=0.68, 0.58, 0.53, 0.44; MADRS=26.97, 28.83, 29.39, 29.67 in the first, second, third, and fourth DFFS quartiles, respectively; $p<0.01$). **CONCLUSIONS:** Vortioxetine was significantly superior to agomelatine in terms of change in DFFS total score at weeks 8 and 12. Depressed patients with impaired family functioning showed worse overall functioning and QoL, suggesting that attention should be given to family functioning of depressed patients.

PMH53

ANTIPSYCHOTICS TREATMENT AND QUALITY OF LIFE IN SCHIZOPHRENIA PATIENTS

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OBJECTIVES: A study was done at tertiary care hospital to find the clinical evaluations with particular identification and quality of life in schizophrenia patients. Patients visiting the psychiatry clinic were screened for psychological problems using a standard questionnaire and patients with history of psychiatry problems over a period of years. **METHODS:** It was a possible observational study for 6 months in a hospital. The study enrolled 150 in-patients and out-patients with Schizophrenia. Patients were included in the study who met addition criteria after obtaining their knowledgeable permission. Patient history, principal symptoms, physical examination and computed tomography scan information were taken as the pretreatment evaluation. Antipsychotic drugs (Chlorpromazine and Haloperidol) were used in the patients to find the clinical evaluations and quality of life was analyzed. **RESULTS:** A study was conducted to search the clinical profile, patient behavioural symptoms of drugs used among schizophrenia patients. A major number of patients who visited the hospital were diagnosed with different psychotic disorders. Among patients who were diagnosed with schizophrenia, 52% were males and 48% were females. Major factors were found to be family history (43%), alcohol (15%), thyroid disorders (7%), family problems (7%), and post menopausal problems (1%). Symptoms shown by the patients were abnormal behaviour (75%), smiling to self (15%), talking to self (29%), hallucinations (39%), aggressive (25%), sleeplessness (42%). Most common people affected were between 20-25 age groups (23%). **CONCLUSIONS:** It was concluded that patients were better recovered through treatment using Chlorpromazine and Haloperidol. Electro convulsive therapy through supportive treatment was used to improve the quality of life of the patients.

MENTAL HEALTH – Health Care Use & Policy Studies

PMH54

THE ASSOCIATION OF VALUE-BASED BENEFIT DESIGN AND BEHAVIORAL HEALTH MEDICATION USAGE

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OBJECTIVES: Measure the impact of reduced copay intervention on medication usage, healthcare utilization and costs, and health status. **METHODS:** A self-insured global healthcare company followed 529 insured members with anxiety and/or depression to determine the impact of waived pharmacy copays for anxiety and depression medications. Primary outcome was pre-post change in medication possession ratio (MPR). Secondary outcomes included initiation of medication, healthcare utilization, medical/pharmacy costs, and percentage of generic medication. A repeated-measures multivariable model was utilized to measure intervention impact, adjusting for age, gender, number of prescriptions, and comorbidity index. **RESULTS:** Unadjusted analysis showed the copay intervention group was significantly more likely to start a new medication (31.4% vs. 29.5%, $p = 0.033$) and more likely to fill a generic medication (85.1% vs. 80.5%, $p < 0.0001$), and had higher average MPR (65.4% vs. 60.7%, $p = 0.004$) than the control group. Healthcare utilization was similar pre-post intervention. Multivariable adjusted analysis revealed a 4.5% increase in MPR after the intervention (95% CI 2.2% - 6.8%, $p = 0.0002$). **CONCLUSIONS:** Eliminating pharmacy copay for depression and/or anxiety medications was associated with increased medication initiation and adherence. This value-based benefit design could be expanded with additional follow-up to measure longer-term trends and with other medication classes to assess similar impact.

PMH55

METAREVIEW OF FINDINGS IN EXISTING LITERATURE REVIEWS COVERING BEHAVIORAL HEALTH-PHYSICAL HEALTH INTEGRATION STUDIES

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OBJECTIVES: This metareview identifies the common elements associated with published behavioral health-physical health (BH-PH) collaboration/integration strategies for managing comorbid conditions. **METHODS:** PubMed, Cochrane Library, and the Academy (AHRQ) were searched using keywords "review" or "meta-analysis" and any combination of: "collaboration," "integrated," "behavioral," "mental," "primary care," "general practice," "depression," "schizophrenia," "bipolar," "panic," anxiety," "alcohol," and "substance abuse." **RESULTS:** The search identified 110 systematic reviews and/or meta-analyses covering BH-PH collaboration/integration strategies, referencing almost 3,000 studies. Most studies addressed integration of BH services into primary care (PC), primarily major depression (less frequently anxiety, somatization, alcohol and addiction disorders) in adults and/or elderly. Some described integration of BH services into outpatient and community settings—effective venues for strategies like diet and exercise—or PH services in BH settings. Provider integration strategies usually included a psychiatrist or clinical psychologist available for PC consultation, but also therapists, BH-trained clinical nurses, social workers, care managers, and/or community health workers. Integrated BH-PH care models achieved clinically meaningful improvements in depression- and anxiety-related primary and secondary outcomes. Recent individual studies have also reported improvements in medical/clinical outcomes (e.g., HbA1c in TEAMcare study) and physical functioning. The extent of integration was not significantly associated with depression or anxiety outcomes. No best practices (e.g., colocation) have been definitively validated as significant predictors for promoting positive health outcomes; rather, successful strategies implement multifaceted, system-level interventions, including brief psychologi-